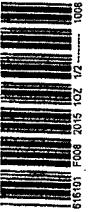


EXHIBIT C

Hⁿ Health Net[®]
 www.Healthnet.com
 HEALTH NET
 of NEW JERSEY, INC.
 90 Matawan Road 5th Floor
 Matawan, NJ 07747

Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: Charter POS
 Plan Year: 01/01/2010 -12/31/2010
 Client Number: A29986
 Process Date: 04/09/2010



616191 F008 2015 1OZ 1/2 ----- 1008

[REDACTED]
 [REDACTED]
 [REDACTED]

Patient's Responsibility

Deductible:	0.00
Coinsurance:	0.00
Copay Amount:	0.00
Not Covered:	-2,028.28
Provider May Bill You:	-2,028.28

Health Net Paid

Payment Amount:	2028.28
-----------------	---------

Explanation of Benefits

~THIS IS NOT A BILL~

~RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS~

Go paperless! View this document easily and conveniently on our secure website. Sign up today at www.healthnet.com and choose to receive email notifications whenever a new Explanation of Benefits is available. Already registered online? Simply change your delivery preferences at www.healthnet.com > Manage my account.

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Questions?

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- If you are covered by more than one carrier for medical benefits, file all claims with each carrier and provide each with information regarding all of the coverage you have.
- If you believe there has been fraud, waste or abuse, in relation to your health coverage, please contact Health Net at 1-800-747-0877. All calls will be kept confidential, and you may remain anonymous if you choose.

UNDERSTANDING YOUR EXPLANATION OF BENEFITS

PAGE 2

CLAIM #	The Health Net reference number assigned to the claim.
DATE(S) OF SERVICE	Indicates the date or range of dates on which you received the service.
SERVICE	Brief description of the service provided (i.e.; Office Visit)
BILLED CHARGES	The full amount billed by the physician or provider for the service.
NOT COVERED	Charges that are not covered by the plan, such as: the difference between BILLED CHARGES and ALLOWED CHARGES; the penalty for failing to obtain prior authorization on required services; or services not covered by your Health Net plan. This portion is your responsibility to pay.
REDUCTIONS	An adjustment made by Health Net to the BILLED CHARGES. You are not responsible for this amount. If you are billed for this amount, do not pay the provider – contact Customer Service at the phone number located on the first page of this Explanation of Benefits.
ALLOWED CHARGES	Total BILLED CHARGES minus any NOT COVERED charges and REDUCTIONS equals the ALLOWED CHARGES.
OTHER INSURANCE	The amount paid by another insurance carrier, if applicable. The OTHER INSURANCE amount is subtracted from the ALLOWED CHARGES and may reduce your payment responsibility.
DEDUCTIBLE	Where applicable, the amount that is set by your plan that is your responsibility to pay before Health Net begins to pay benefits. This amount is applied to the yearly deductible. Please see the bottom of the statement for the individual and family deductible amount met to date.
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MEMBER PAYS	Total amount you are responsible for paying to the physician/provider. This includes any applicable NOT COVERED, DEDUCTIBLE, COINSURANCE, and COPAY amount.
REMARK CODE(S)	The remark code and its corresponding explanation (which can be found at the bottom of the statement) provide a detailed explanation for the payment or denial for this service.
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Denied Claims – Your Rights Under ERISA:

If your claim has been denied, you can find the terms supporting the denial in your evidence of coverage issued to you by Health Net. The applicable guidelines and clinical rationale used in making this decision are available upon request at no charge to you. If your health coverage is provided through an employer and your employer is not a church or a governmental organization (like a school district, city, state, or board of education) or a union, you may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, if all required reviews of your claim have been completed and your claim has not been approved.



HEALTH NET
of NEW JERSEY, INC.
90 Matawan Road 5th Floor
Matawan, NJ 07747

Page: 5

Patient:
Subscriber:
Health Net ID:

Plan:

Plan Year:

01/01/2009 -12/31/2009

Client Number:

A29986

Process Date:

10/02/2009

COBB000055

Revised document any questions contact Customer Service at 1-800-441-5741

EXPLANATION OF BENEFITS

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Provider Name: Dannette V. Marin, RN

Provider ID: ZJ2399

Claim#: 2009050446155892

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Surgical Services										
05/04/2009	324.25	0.00	324.25	0.00	0.00	0.00	0.00	0.00	0.00	PW
Service: Surgical Services										
05/04/2009	3,386.00	0.00	3,386.00	0.00	0.00	0.00	0.00	0.00	0.00	PW
Service: Surgical Services										
05/04/2009	3,257.50	0.00	3,257.50	0.00	0.00	0.00	0.00	0.00	0.00	PW
Claims Sub Total	6,967.75	0.00	6,967.75	0.00	0.00	0.00	0.00	0.00	0.00	
Total	6,967.75	0.00	6,967.75	0.00	0.00	0.00	0.00	0.00	0.00	

Explanation Of Remark Codes

PW THIS CLAIM HAS BEEN DENIED DUE TO THE FACT THAT WE HAVE NEVER RECEIVED A RELATED BILL FROM THE HOSPITAL. WE WILL REVIEW AND PROCESS YOUR CLAIM AS SOON AS THE HOSPITAL BILL IS RECEIVED.

Member Deductible to Date	98.00	Family Deductible to Date	98.00	Member Coinsurance to Date	0.00	Family Coinsurance to Date	0.00	Health Net Paid to Date	809.50
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HP Health Net
 www.healthnet.com
 HEALTH NET
 of NEW JERSEY, INC.
 90 Malawan Road 5th Floor
 Malawan, NJ 07747

Page: 3

Patient:
 Subscriber:
 Health Net ID:

Plan:

Plan Year:

Client Number:

Process Date:

01/01/2010 - 12/31/2010

A29986

04/09/2010

Charter POS

COBB000057

EXPLANATION OF BENEFITS

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Provider Name: Danilo c. Mangunay, MD

Provider ID: ZL2513

Claim#: 2010020251316736

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Neurology Procedure										
02/02/2010	707.00	0.00	707.00	0.00	0.00	0.00	0.00	0.00	0.00	6C
Service: Neurology Procedure										
02/02/2010	0.00	-707.00	0.00	707.00	0.00	0.00	0.00	707.00	-707.00	
Service: Neurology Procedure										
02/02/2010	679.00	0.00	679.00	0.00	0.00	0.00	0.00	0.00	0.00	6C
Service: Neurology Procedure										
02/02/2010	0.00	-660.64	0.00	660.64	0.00	0.00	0.00	660.64	-660.64	B
Service: Neurology Procedure										
02/02/2010	790.00	0.00	790.00	0.00	0.00	0.00	0.00	0.00	0.00	6C



EXPLANATION OF BENEFITS

Page: 4



HEALTH NET
of NEW JERSEY, INC.
90 Matawan Road 5th Floor
Matawan, NJ 07747

Patient: [REDACTED]
Subscriber: [REDACTED]
Health Net ID: [REDACTED]
Plan: [REDACTED]
Plan Year: 01/01/2010 - 12/31/2010
Client Number: A29986
Process Date: 04/09/2010
Charter POS
COBB0000058

Claim continued from previous page: Claim # 2010020251316736

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Neurology Procedure										
02/02/2010	0.00	-660.64	0.00	660.64	0.00	0.00	0.00	660.64	-660.64	B
Claims Sub Total	2,176.00	-2,028.28	2,176.00	2,028.28	0.00	0.00	0.00	2,028.28	-2,028.28	
Total	2,176.00	-2,028.28	2,176.00	2,028.28	0.00	0.00	0.00	2,028.28	-2,028.28	

Explanation Of Remark Codes

6C CHARGE DISALLOWED. THIS CODE HAS BEEN CHANGED TO A MORE APPROPRIATE CODE BASED ON THE CIRCUMSTANCES.

B FOR COVERED SERVICES, THE MBR IS RESP FOR APPLICABLE COPAY/DEDUCTIBLE/COINSURANCE. ALSO, IF THE PROVIDERS BILLED AMOUNT EXCEEDS HEALTH NET'S ALLOWED AMOUNT, MBR IS RESP FOR THE DIFFERENCE.

Member Deductible to Date 1,000.00 Family Deductible to Date 1,000.00 Member Coinsurance to Date 3,000.00 Family Coinsurance to Date 3,000.00 Health Net Paid to Date 84,930.32



HEALTH NET
of NEW JERSEY, INC.
90 Malawan Road 5th Floor
Malawan, NJ 07747

Page: 5

Patient:
Subscriber:
Health Net ID:

Charter POS

Plan:

01/01/2009 - 12/31/2009

Client Number:

A29986

Process Date:

10/02/2009

Revised document any questions contact Customer Service at 1-800-441-5741

EXPLANATION OF BENEFITS

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Provider Name: Marc A. Cohen, MD

Provider ID: Z13293

Claim#: 2009050446155891

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Surgical Services										
05/04/2009	1,297.00	0.00	1,297.00	0.00	0.00	0.00	0.00	0.00	0.00	PW
Service: Surgical Services										
05/04/2009	13,544.00	0.00	13,544.00	0.00	0.00	0.00	0.00	0.00	0.00	PW
Service: Surgical Services										
05/04/2009	13,030.00	0.00	13,030.00	0.00	0.00	0.00	0.00	0.00	0.00	PW
Claims Sub Total										
	27,871.00	0.00	27,871.00	0.00	0.00	0.00	0.00	0.00	0.00	
Provider Name: Marc A. Cohen, MD										
Provider ID: Z13293										
Claim#: 2009050446155891										
Service: Surgical Services										
05/04/2009	1,297.00	0.00	1,297.00	0.00	0.00	0.00	0.00	0.00	0.00	PW



Page: 6

Patient: [REDACTED]
Subscriber: [REDACTED]
Health Net ID: [REDACTED]
Plan: [REDACTED]
Plan Year: 01/01/2009 - 12/31/2009
Client Number: A29986
Process Date: 10/02/2009

Claim # 2009050446169645

[illegible]



EXPLANATION OF BENEFITS

Page: 7

Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: [REDACTED]
 Charter POS
 Plan Year: 01/01/2009 - 12/31/2009
 Client Number: A29986
 Process Date: 10/02/2009

Provider Name: Marc A. Cohen, MD
 Provider ID: Z13293

Claim#: 2009072146643538

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Office Visits										
07/21/2009	130.00	0.00	130.00	0.00	0.00	0.00	0.00	0.00	0.00	IS JK
Claims Sub Total	130.00	0.00	130.00	0.00	0.00	0.00	0.00	0.00	0.00	
Total	74,628.00	0.00	74,628.00	0.00	0.00	0.00	0.00	0.00	0.00	

Explanation Of Remark Codes

PW THIS CLAIM HAS BEEN DENIED DUE TO THE FACT THAT WE HAVE NEVER RECEIVED A RELATED BILL FROM THE HOSPITAL. WE WILL REVIEW AND PROCESS YOUR CLAIM AS SOON AS THE HOSPITAL BILL IS RECEIVED.

IS THIS IS A DUPLICATE SERVICE PREVIOUSLY CONSIDERED. IF PAYMENT WAS MADE TO YOU DIRECTLY, PLEASE FORWARD PAYMENT TO THE PHYSICIAN/PROVIDER IF YOU HAVE NOT ALREADY DONE SO.

JK CHARGE DENIED. ONLY ONE OFFICE/HOSPITAL VISIT CHARGE ALLOWED PER DATE OF SERVICE.

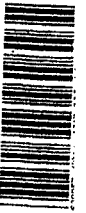
Member Deductible to Date	Family Deductible to Date	Member Coinsurance to Date	Family Coinsurance to Date	Health Net Paid to Date
98.00	98.00	0.00	0.00	809.50



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 HEALTH NET
 of NEW JERSEY, INC.
 90 Matawan Road 5th Floor
 Matawan, NJ 07747

PAGE 1

Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: Charter
 Plan Year: 01/01/2010 -12/31/2010
 Client Number: A29986
 Process Date: 05/14/2010



620957 F01K 4717 20Z 1/6 ----- 787

Patient's Responsibility

Deductible:	0.00
Coinsurance:	0.00
Copay Amount:	0.00
Not Covered:	73,208.00
Provider May Bill You:	73,208.00

Health Net Paid

Payment Amount:	0.00
-----------------	------

Explanation of Benefits

~THIS IS NOT A BILL~

~RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS~

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Health Net
HEALTH NET
of NEW JERSEY, INC.
90 Malawan Road 5th Floor
Malawan, NJ 07747
www.healthnet.com

Page: 3

Patient: [REDACTED]
Subscriber: [REDACTED]
Health Net ID: [REDACTED]
Plan: [REDACTED]
Plan Year: 01/01/2010 - 12/31/2010
Client Number: A29986
Process Date: 05/14/2010

COBB000023

EXPLANATION OF BENEFITS

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Provider Name: Marc A. Cohen, MD
Provider ID: Z13293
Claim#: 2010020252687665

Dates) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Surgical Services										
02/02/2010	1,655.00	1,655.00	0.00	0.00	0.00	0.00	0.00	0.00	1,655.00	NX
Service: Surgical Services										
02/02/2010	1,297.00	1,297.00	0.00	0.00	0.00	0.00	0.00	0.00	1,297.00	NX IS
Service: Surgical Services										
02/02/2010	29,154.00	29,154.00	0.00	0.00	0.00	0.00	0.00	0.00	29,154.00	NX
Service: Surgical Services										
02/02/2010	15,344.00	15,344.00	0.00	0.00	0.00	0.00	0.00	0.00	15,344.00	NX
Service: Surgical Services										
02/02/2010	23,758.00	23,758.00	0.00	0.00	0.00	0.00	0.00	0.00	23,758.00	NX

V.1.2009

copy



630957 P01N 4718 502 33



Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: Charter POS
 Plan Year: 01/01/2010 -12/31/2010
 Client Number: A29986
 Process Date: 03/04/2010



610975 F007 4693 10Z 1/2 ----- 2347

[REDACTED]
 [REDACTED]
 [REDACTED]

Patient's Responsibility

Deductible:	0.00
Coinsurance:	0.00
Copay Amount:	0.00
Not Covered:	73,208.00
Provider May Bill You:	73,208.00

Health Net Paid

Payment Amount:	0.00
-----------------	------

Explanation of Benefits

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PAGE 2

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If your claim has been denied, you can find the terms supporting the denial in your evidence of coverage issued to you by Health Net. The applicable guidelines and clinical rationale used in making this decision are available upon request at no charge to you. If your health coverage is provided through an employer and your employer is not a church or a governmental organization (like a school district, city, state, or board of education) or a union, you may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, if all required reviews of your claim have been completed and your claim has not been approved.

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Metawan, NJ 07747

EXPLANATION OF BENEFITS

Page: 7

Patient: [REDACTED]
Subscriber: [REDACTED]
Health Net ID: [REDACTED]
Plan: [REDACTED]
Plan Year: 01/01/2010 - 12/31/2010
Client Number: A29986
Process Date: 03/04/2010
Charter POS

COBB000027

Claim continued from previous page:

Claim # 2010020250778690

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Surgical Services										
02/02/2010	2,000.00	2,000.00	0.00	0.00	0.00	0.00	0.00	0.00	2,000.00	NX
Claims Sub Total	73,208.00	73,208.00	0.00	0.00	0.00	0.00	0.00	0.00	73,208.00	
Total	73,208.00	73,208.00	0.00	0.00	0.00	0.00	0.00	0.00	73,208.00	

Explanation Of Remark Codes

NX CHARGE DENIED. PROVIDER IS NOT WITHIN YOUR ASSIGNED NETWORK OF PROVIDERS AND THE SERVICE IS NOT CONSIDERED EMERGENT. PROVIDER MAY BILL YOU.

Member Deductible to Date 105.00 Family Deductible to Date 105.00 Member Coinsurance to Date 0.00 Family Coinsurance to Date 0.00 Health Net Paid to Date 0.00

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 Matawan, NJ 07747

Page: 3

Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: [REDACTED]
 Plan Year: 01/01/2010 - 12/31/2010
 Client Number: A29986
 Process Date: 03/04/2010
 Charter POS
 COBB000028

**EXPLANATION OF BENEFITS
 THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS**

Provider Name: Marc A. Cohen, MD
Provider ID: Z13293
Claim#: 2010020250778690

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Surgical Services										
02/02/2010	1,655.00	1,655.00	0.00	0.00	0.00	0.00	0.00	0.00	1,655.00	NX
Service: Surgical Services										
02/02/2010	1,297.00	1,297.00	0.00	0.00	0.00	0.00	0.00	0.00	1,297.00	NX
Service: Surgical Services										
02/02/2010	29,154.00	29,154.00	0.00	0.00	0.00	0.00	0.00	0.00	29,154.00	NX
Service: Surgical Services										
02/02/2010	15,344.00	15,344.00	0.00	0.00	0.00	0.00	0.00	0.00	15,344.00	NX
Service: Surgical Services										
02/02/2010	23,758.00	23,758.00	0.00	0.00	0.00	0.00	0.00	0.00	23,758.00	NX

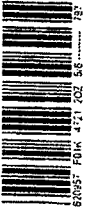


PAGE 1

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Dr. Most

Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: Charter
 Plan Year: 01/01/2010 -12/31/2010
 Client Number: A29986
 Process Date: 05/14/2010



620957 F01K 4721 20Z 5/6 787

ERIC COBB
 128 W WARREN ST
 S BOUND BROOK, NJ 08880-1330

Patient's Responsibility

Deductible:	0.00
Coinsurance:	0.00
Copay Amount:	0.00
Not Covered:	21,930.00
Provider May Bill You:	21,930.00

Health Net Paid

Payment Amount:	0.00
-----------------	------

Explanation of Benefits

~THIS IS NOT A BILL~

~RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS~

Go paperless! View this document easily and conveniently on our secure website. Sign up today at www.healthnet.com and choose to receive email notifications whenever a new Explanation of Benefits is available. Already registered online? Simply change your delivery preferences at www.healthnet.com > Manage my account.

This detail explanation will clarify your payment responsibilities or reimbursement. Please see reverse side for important additional information and telephone numbers.

Questions?

Please contact us at www.healthnet.com or at One Far Mill Crossing P.O. BOX 904 Shelton, CT 06484 or call us at (800) 441-5741.

- If you are covered by more than one carrier for medical benefits, file all claims with each carrier and provide each with information regarding all of the coverage you have.
- If you believe there has been fraud, waste or abuse, in relation to your health coverage, please contact Health Net at 1-800-747-0877. All calls will be kept confidential, and you may remain anonymous if you choose.

COBB000043

CLAIM #	The Health Net reference number assigned to the claim.
DATE(S) OF SERVICE	Indicates the date or range of dates on which you received the service.
SERVICE	Brief description of the service provided (i.e.; Office Visit)
BILLED CHARGES	The full amount billed by the physician or provider for the service.
NOT COVERED	Charges that are not covered by the plan, such as: the difference between BILLED CHARGES and ALLOWED CHARGES; the penalty for failing to obtain prior authorization on required services; or services not covered by your Health Net plan. This portion is your responsibility to pay.
REDUCTIONS	An adjustment made by Health Net to the BILLED CHARGES. You are not responsible for this amount. If you are billed for this amount, do not pay the provider – contact Customer Service at the phone number located on the first page of this Explanation of Benefits.
ALLOWED CHARGES	Total BILLED CHARGES minus any NOT COVERED charges and REDUCTIONS equals the ALLOWED CHARGES.
OTHER INSURANCE	The amount paid by another insurance carrier, if applicable. The OTHER INSURANCE amount is subtracted from the ALLOWED CHARGES and may reduce your payment responsibility.
DEDUCTIBLE	Where applicable, the amount that is set by your plan that is your responsibility to pay before Health Net begins to pay benefits. This amount is applied to the yearly deductible. Please see the bottom of the statement for the individual and family deductible amount met to date.
COINSURANCE	Where applicable, the percentage set by your plan of ALLOWED CHARGES that you are responsible for paying.
COPAY	Where applicable, the dollar amount set by your plan that you pay a provider or facility.
HEALTH NET PAID	The amount paid by Health Net. It is the amount remaining after applicable OTHER INSURANCE, DEDUCTIBLE, COINSURANCE, and COPAY amounts have been subtracted from the ALLOWED CHARGES. Note: Health Net may be required to pay a non-participating physician/provider directly. If Health Net pays the non-participating physician/provider directly and you have already paid the non-participating physician/provider for the service(s), the non-participating physician/provider is obligated to refund any duplicate payment. Contact the non-participating physician/provider directly with questions about any refund.
MEMBER PAYS	Total amount you are responsible for paying to the physician/provider. This includes any applicable NOT COVERED, DEDUCTIBLE, COINSURANCE, and COPAY amount.
REMARK CODE(S)	The remark code and its corresponding explanation (which can be found at the bottom of the statement) provide a detailed explanation for the payment or denial for this service.
INTEREST	Interest paid as applicable, based upon applicable state and federal laws.

New Jersey Notice of Appeal and Grievance Rights

MEDICAL NECESSITY ISSUES (Denial of coverage for Medical Necessity reasons) If you disagree with this determination, you, or your designee (with specific written consent from you) may initiate an appeal within one hundred eighty (180) calendar days of the receipt of the Explanation of Benefits setting forth the determination. To initiate the Health Net appeal process, please either call Health Net at 1-888-747-8494 or submit written comments, documents and other information relevant to the appeal to: Health Net, One Far Mill Crossing, P.O. Box 857, CT 110-05-06, Shelton, CT 06484-0857, Attn: Clinical Appeals.

~INTERNAL & EXTERNAL APPEAL: Health Net will process your first level appeal within five (5) business days of its receipt. At any level of appeal you have the right to representation by anyone of your choosing. If the denial is upheld at the first level, you may request a second level internal appeal, the process for which will be described in your first-level decision letter. If you are still dissatisfied with Health Net's decision on a second level appeal, you will be afforded the opportunity to have your appeal heard by an external review agency. The steps you must take to do so will be explained in the second level decision letter. External appeals are not available to enrollees in workers' compensation, or self-funded plans. Additionally, you have the right to contact the New Jersey Department of Banking and Insurance at 1-609-292-5360 at any time, if you are dissatisfied with Health Net's handling of your issue.

~EXPEDITED APPEALS: Health Net will provide an expedited appeal for medical conditions that require urgent care. You may request such an expedited appeal by calling the appropriate number listed above. If your condition warrants, Health Net will process your appeal within thirty-six (36) hours.

GRIEVANCES/COMPLAINTS: (For complaints for any reason other than medical necessity) If you disagree with this determination, you, or your designee (with specific written consent from you) may initiate a grievance within one hundred eighty (180) calendar days from your receipt of this Explanation of Benefits. To initiate the Health Net grievance process, please either call Health Net at 1-888-747-8494 or submit written comments, documents and other information relevant to the grievance to the address below. Health Net will process your grievance within thirty (30) calendar days of its receipt. The written request for a grievance of this determination should be sent to: Health Net, One Far Mill Crossing, P.O. Box 904, CT 110-05-05, Shelton, CT 06484-0860.

You have the right to contact the New Jersey Department of Banking and Insurance at 1-609-292-5360 at any time, if you are dissatisfied with Health Net's handling of your issue.

~EXPEDITED GRIEVANCES/COMPLAINTS: Health Net will provide an expedited review where necessary. You may request such an expedited review by calling the appropriate number listed above. If your condition warrants, Health Net will process your grievance within thirty-six (36) hours.

REQUESTS FOR ADDITIONAL INFORMATION: Please note that the time frames described above will be expanded where Health Net requests additional information that is necessary to decide your appeal.

You have the right to contact the New Jersey Department of Banking and Insurance at 1-609-292-5360 at any time, if you are dissatisfied with Health Net's handling of your issue.

Denied Claims – Your Rights Under ERISA:

If your claim has been denied, you can find the terms supporting the denial in your evidence of coverage issued to you by Health Net. The applicable guidelines and clinical rationale used in making this decision are available upon request at no charge to you. If your health coverage is provided through an employer and your employer is not a church or a governmental organization (like a school district, city, state, or board of education) or a union, you may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, if all required reviews of your claim have been completed and your claim has not been approved.



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Malawan, NJ 07747
www.healthnet.com

Page: 3

Patient: [REDACTED]
Subscriber: [REDACTED]
Health Net ID: [REDACTED]
Plan: [REDACTED]
Plan Year: 01/01/2010 - 12/31/2010
Client Number: A29986
Process Date: 05/14/2010
Charter

EXPLANATION OF BENEFITS
THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Provider Name: Michael D. Most, MD
Provider ID: ZH1125

Claim#: 2010020252687666

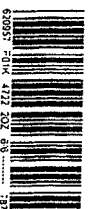
Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Surgical Services										
02/02/2010	8,495.00	8,495.00	0.00	0.00	0.00	0.00	0.00	0.00	8,495.00	NX
Service: Surgical Services										
02/02/2010	5,900.00	5,900.00	0.00	0.00	0.00	0.00	0.00	0.00	5,900.00	NX
Service: Surgical Services										
02/02/2010	7,535.00	7,535.00	0.00	0.00	0.00	0.00	0.00	0.00	7,535.00	NX
Claims Sub Total										
	21,930.00	21,930.00	0.00	0.00	0.00	0.00	0.00	0.00	21,930.00	
Total										
	21,930.00	21,930.00	0.00	0.00	0.00	0.00	0.00	0.00	21,930.00	

Explanation Of Remark Codes

NX CHARGE DENIED. PROVIDER IS NOT WITHIN YOUR ASSIGNED NETWORK OF PROVIDERS AND THE SERVICE IS NOT CONSIDERED EMERGENT. PROVIDER MAY BILL YOU.

Member Deductible to Date 164.90 Family Deductible to Date 164.90 Member Coinsurance to Date 0.00 Family Coinsurance to Date 0.00 Health Net Paid to Date

V.1.2009



600357 701K 4722 202 830 187

COBB000047

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Page: 3

Patient: [REDACTED]
 Subscriber: [REDACTED]
 Health Net ID: [REDACTED]
 Plan: [REDACTED]
 Plan Year: 01/01/2010 - 12/31/2010
 Client Number: A29986
 Process Date: 03/26/2010

COBB000013

EXPLANATION OF BENEFITS

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Provider Name: BERGEN ANESTHESIA & PAIN MGT.

Provider ID: J29724

Claim#: 2010020251208360

Date(s) of Service	Billed Charges	Not Covered	Reductions	Allowed Charges	Deductible	Coinsurance	Copay	Health Net Paid	Member Pays	Remark Codes
Service: Anesthesia Services										
02/02/2010	4,950.00	0.00	0.00	4,950.00	780.74	1,245.38	0.00	2,923.88	2,026.12	BF OL
Claims Sub Total	4,950.00	0.00	0.00	4,950.00	780.74	1,245.38	0.00	2,923.88	2,026.12	
Total	4,950.00	0.00	0.00	4,950.00	780.74	1,245.38	0.00	2,923.88	2,026.12	

Explanation Of Remark Codes

BF PROVIDER MAY BILL YOU FOR THIS COINSURANCE PERCENTAGE PER YOUR PLAN.

OL THIS AMOUNT HAS BEEN APPLIED TOWARD YOUR YEARLY DEDUCTIBLE. PROVIDER MAY BILL YOU.

Member Deductible to Date	Family Deductible to Date	Member Coinsurance to Date	Family Coinsurance to Date	Health Net Paid to Date
1,000.00	1,000.00	3,000.00	3,000.00	82,902.04





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50 Madison Road 5th Floor
Metuchen, NJ 07741

REMITTANCE ADVICE

PAGE 1

Payee Name BERGEN ANESTHESIA & PAIN MGT.
PO BOX 135
Payee Address ORADELL, NJ 07649-0135

Vendor # 0X00J29724
SUITE 4064
Payee Tax ID 331070285
Process Date 03/26/2010
Bank Code 00
Payer Tax ID Z23241303

Patient Name
Patient Acct # 88006867
Subscriber Name

KNID
Contract Charter POS
Date Rec 03/08/2010

Check #
Provider # J29724
Medicaid

Type E
NPI 154839704

Service Date	Proc Code	Modifier	Units	Billed	Exceeds Standard	Contract Adjustment	Allowed	Deductible	Coinurance	Copay	Patient Resp	Benefit Payable	Reason Code
02/02/2010	00600	AA	18	4,950.00	0.00	0.00	4,950.00	780.74	1,245.36	0.00	2,026.12	2,973.88	BF OL
CLAIM TOTALS				4,950.00	0.00	0.00	4,950.00	780.74	1,245.36	0.00	2,026.12	2,973.88	

Reason Codes:
BF MEMBER RESPONSIBLE FOR THIS COINSURANCE DOLLAR AMOUNT.
OL THIS AMOUNT HAS BEEN APPLIED TO THE MEMBER'S YEARLY DEDUCTIBLE - THE MEMBER IS RESPONSIBLE FOR PAYMENT.

TOTALS FOR THIS REMIT	Billed	Exceeds Standard	Contract Adjustment	Allowed	Deductible	Coinurance	Copay	Patient Responsibility	Benefit Payable
	4,950.00	0.00	0.00	4,950.00	780.74	1,245.36	0.00	2,026.12	2,973.88

Remark Codes: A=ADJUSTED; D=DISCOUNT; P=PENALTY; C=CAPITATION; I=PRIME INPT; PMT; W=WITHHOLD

Check / EFT #: 0003803236

Check Amt: 2,973.88

Check Date: 03/31/2010

Total Interest: 0.00

Vendor 0X00J29724 Totals

2,973.88

If you suspect fraud or abuse please contact the Fraud Hotline at: (800) 747-0877

For questions, please contact the Provider Call Unit at One Far Mill Crossing P.O. Box 904 Shelton, CT 06484 or call (800) 435-7865



COBB000015